# EXHIBIT "5"

# EXHIBIT "5"

# INDEX

**Footnote 12**: (BS) Nos. 634 – 644

**Footnote 13**: (BS) Nos. 186-191

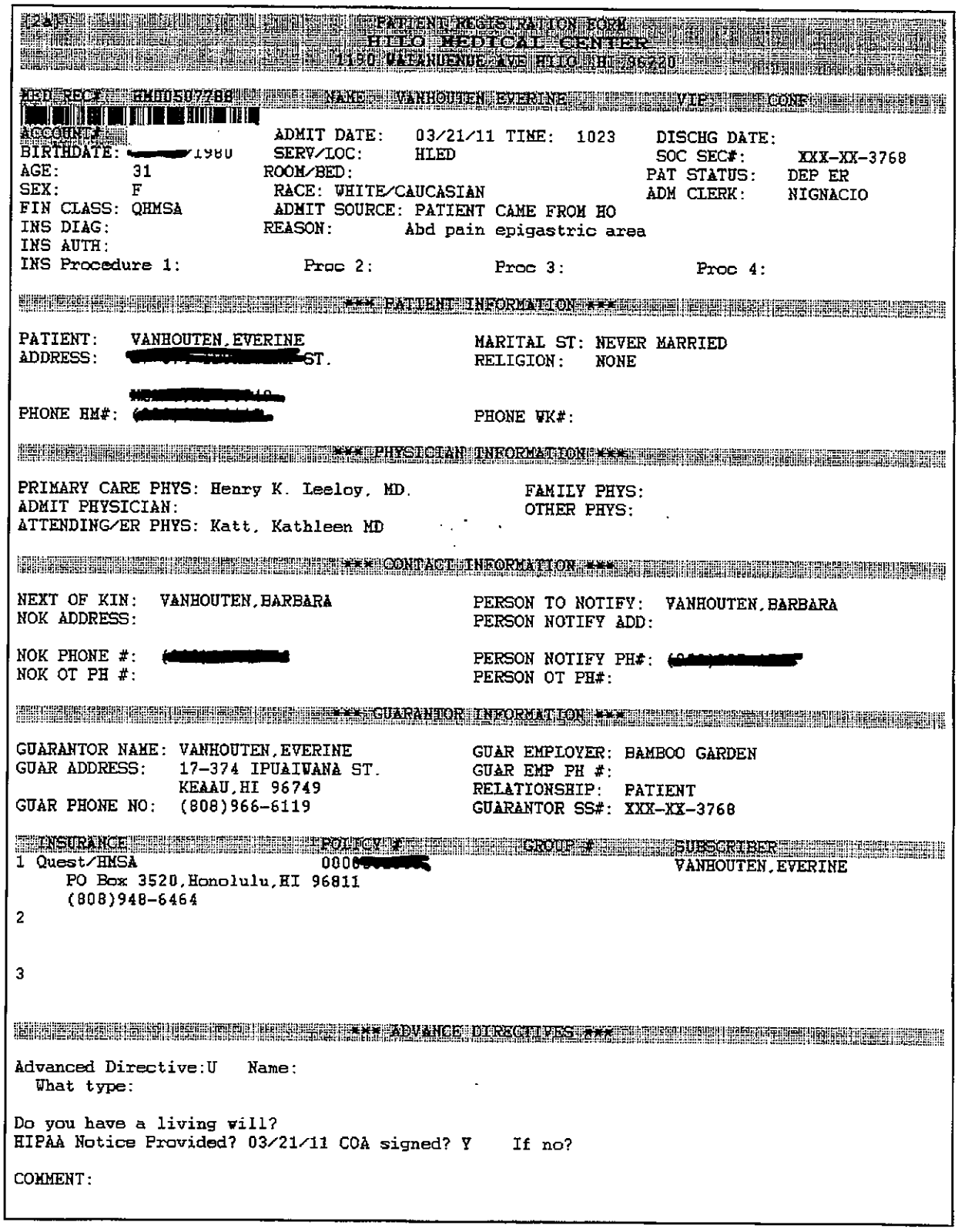
**Footnote 14**: (BS) Nos. 137

**Footnote 15**: (BS) Nos. 49-50

**Footnote 16**: (BS) Nos. 62

**Footnote 17**: (BS) Nos. 602-606

# FOOTNOTE 12



PATIENT REGISTRATION FORM
HILO MEDICAL CENTER
1190 WAIANUENUE AVE HILO HI 96720

MRD REC#: HM00507788 NAME: VANHOUTEN EVERINE VIP CODE:
[redacted]
ACCOUNT#: [redacted] ADMIT DATE: 03/21/11 TIME: 1023 DISCHG DATE:
BIRTHDATE: [redacted]1980 SERV/LOC: HLED SOC SEC#: XXX-XX-3768
AGE: 31 ROOM/BED: PAT STATUS: DEP ER
SEX: F RACE: WHITE/CAUCASIAN ADM CLERK: NIGNACIO
FIN CLASS: QHMSA ADMIT SOURCE: PATIENT CAME FROM HO
INS DIAG: REASON: Abd pain epigastric area
INS AUTH:
INS Procedure 1: Proc 2: Proc 3: Proc 4:

*** PATIENT INFORMATION ***

PATIENT: VANHOUTEN,EVERINE MARITAL ST: NEVER MARRIED
ADDRESS: [redacted]ST. RELIGION: NONE
[redacted]
PHONE HM#: [redacted] PHONE WK#:

*** PHYSICIAN INFORMATION ***

PRIMARY CARE PHYS: Henry K. Leeloy, MD. FAMILY PHYS:
ADMIT PHYSICIAN: OTHER PHYS:
ATTENDING/ER PHYS: Katt, Kathleen MD

*** CONTACT INFORMATION ***

NEXT OF KIN: VANHOUTEN,BARBARA PERSON TO NOTIFY: VANHOUTEN,BARBARA
NOK ADDRESS: PERSON NOTIFY ADD:
NOK PHONE #: [redacted] PERSON NOTIFY PH#: [redacted]
NOK OT PH #: PERSON OT PH#:

*** GUARANTOR INFORMATION ***

GUARANTOR NAME: VANHOUTEN,EVERINE GUAR EMPLOYER: BAMBOO GARDEN
GUAR ADDRESS: 17-374 IPUAIWANA ST. GUAR EMP PH #:
KEAAU,HI 96749 RELATIONSHIP: PATIENT
GUAR PHONE NO: (808)966-6119 GUARANTOR SS#: XXX-XX-3768

| INSURANCE | POLICY # | GROUP # | SUBSCRIBER |
|---|---|---|---|
| 1 Quest/HMSA<br>PO Box 3520,Honolulu,HI 96811<br>(808)948-6464 | 0000[redacted] | | VANHOUTEN,EVERINE |
| 2 | | | |
| 3 | | | |

*** ADVANCE DIRECTIVES ***

Advanced Directive:U Name:
What type:

Do you have a living will?
HIPAA Notice Provided? 03/21/11 COA signed? Y If no?

COMMENT:

**Hilo Medical Center**
*We Care for Our Community*
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)974-4700

Report Status: Signed

Patient: **VANHOUTEN,EVERINE**
DOB: [redacted]**1980**
Medical Record: **HM00507788**
Account: **HL0010054219**
PCP: **Henry K. Leeloy , MD**
ED Physician: **Katt, Kathleen MD**

Verdana 4d

**Medical History**

**Nursing Note:** Agreed With
**Chief Complaint:** Abdominal Pain

**Stated Complaint:** Abd pain epigastric area

**Time Seen by Provider:** 03/21/11 11:26

**Source:** Patient
**Historian:** Appears accurate
**Exam Limitations:** None

**- History of Present Illness**

**Onset:** Hours
**Severity:** Moderate
**Timing/Duration:** Constant
**Associated Symptoms:** denies: fever/chills, headaches, nausea/vomiting

**- History of Present Illness**

**Notes: (location/quality/context):**
Nursing History of Present Illness

03/21/11 10:43 Nursing Triage HPI Note by Asahara,Elizabeth
Hx of epigastric pain onset 1900 yesterday. Nausea, no vomiting or diarrhea, Discomfort relieved with tylenol, but pain returns.

03/21/11 10:56
This is a 31 y/o female presenting to the ED today c/o epigastric pain. The patient states the pain started at 7 last night and has been persistent throughout the night. The patient denies any N/V/D, headache, or dysuria. The patient states the pain raditates up through the right side of her back. The patient states she has one child a healthy 9 year old. The patient is c/o of sharp pain specifically to her RUQ. The patient also denies any abnormal monthly periods, and states she has never had this pain before. The patient states she also takes a diet pill, that she doesnt know the name of.

(Katt,Kathleen MD)

**Allergies/Adverse Reactions:**
**Allergies**

Name: **VANHOUTEN,EVERINE**
MR #: **HM00507788**
DOB: [redacted]
No Known Allergies Allergy (Unverified 03/21/11 10:40)

**Home Medications:**
**Ambulatory Orders**

Hydrocodone Bit/Acetaminophen [Vicodin 5-500 Tab]1 tab PO Q4HP PRN #20 tablet
None
OMEPRAZOLE [Prilosec Cap]20 mg PO DAILY #30
Ondansetron [Zofran ODT Tab]1 - 2 tab PO Q4HP PRN #20 tab

**Past Medical History**

**Vaccination Hx:** No Influ, No Pneumo

**- Social History**

**Alcohol:** Reports: Occasional
**Drugs:** Reports: Never
**Tobacco:** Reports: Never

**Review of Systems**

**Except as noted:** Reviewed and negative
**Constitutional:** denies: Fever, Chills
**Gastrointestinal:** Abdominal Pain. denies: Nausea, Vomiting, Diarrhea, Constipation
**Genitourinary:** denies: Frequency, Incontinence, Dysuria
**Musculoskeletal:** Back Pain
**Neurological:** denies: Dizziness, Headache

**Physical Exam**

**Vital Signs Reviewed?:** Yes
**Constitutional:** Well Developed/Nourished, Appears Stated Age, Alert
**Eyes:** PERRL, EOMI
**Ears/Nose/Mouth/Throat:** Nml ENT Exam. No: JVD
**Cardiovascular:** Regular Rate & Rhythm, Peri Pulses Strg/Eq
**Respiratory:** BS Normal/Equal Bilat. No: Respiratory Distress
**Gastrointestinal:** Soft, Normal BS, Right CVAT (tenderness). Not: Tender
**Abdominal Tenderness:** RUQ (tenderness), Other (positive Murphy's Sign). Not: Present
**Musculoskeletal:** Full ROM. No: Deformity, Tenderness to Palp, Pedal Edema
**Integumentary:** Normal, Dry
**Neurological:** Alert. Not: Focal Findings
**Psychiatric:** Nml Age Behavior, Alert
**Hema/Lymph/Immun:** No: Bleeding Gums, Lymphadenopathy

**Nursing Vital Signs:**

**Initial Vital Signs**

| | | |
|---|---|---|
| Temperature | 97.0 L | 03/21/11 10:41 |
| Pulse Rate | 82 | 03/21/11 10:41 |
| Respiratory Rate | 16 | 03/21/11 10:41 |
| Blood Pressure | 131/87 H | 03/21/11 10:41 |
| O2 Sat by Pulse Oximetry | 99 | 03/21/11 10:41 |

Name: **VANHOUTEN,EVERINE**
MR #: **HM00507788**
DOB: **02/01/1980**

**Results/Interpretations**

**- US**

**Ultrasound Notes:**

03/21/11 13:42
HHSC\ewyatt, Wyatt, Eric - 3/21/2011 1:36:56 PM
Cholelithiasis

**- Laboratory**

**Result Note:**

03/21/11 11:00

| | | |
|---|---|---|
| 8.4 | 13.6 / 39.6 | 382 |

03/21/11 11:00

| | | | |
|---|---|---|---|
| 139 | 106 | 16 | 91 |
| 4.1 | 21 | 0.90 | |

**Laboratory Tests**

| | 03/21/11 10:45 | 03/21/11 11:00 | Range/Units |
|---|---|---|---|
| WBC | | 8.4 | (3.8-11.2) 10(9)/L |
| RBC | | 4.48 | (3.9-5.2) 10(12)/L |
| Hgb | | 13.6 | (11.6-15.1) g/dL |
| Hct | | 39.6 | (34.1-44.2) % |
| MCV | | 88.6 | (80-100) fL |
| MCH | | 30.5 | (27-33) pg |
| MCHC | | 34.4 | (32-36) g/dL |
| RDW | | 13.4 | (11-15) % |
| Plt Count | | 382 | (150-450) 10(9)/L |
| Neut % | | 52 | (40-70) % |
| Lymph % | | 38 | (20-45) % |
| Mono % | | 7 | (4-10) % |
| Eos % | | 2 | (0-6) % |
| Baso % | | 1 | (0-2) % |
| Differential Method | | Auto | (()) |
| Absolute Neutrophil | | 4.40 | (1.4-7.0) 10(9)/L |
| Absolute Lymphocytes | | 3.20 | (0.7-4.5) 10(9)/L |
| Absolute Monocytes | | 0.60 | (0.1-1.0) 10(9)/L |
| Absolute Eosinophils | | 0.10 | (0-0.6) 10(9)/L |
| Absolute Basophils | | 0.10 | (0-0.2) 10(9)/L |
| Sodium | | 139 | (133-145) mmol/L |

Name: **VANHOUTEN,EVERINE**
MR #: **HM00507788**
DOB: [redacted]1980

| | | | |
|---|---|---|---|
| Potassium | | 4.1 | (3.3-5.1) mmol/L |
| Chloride | | 106 | (96-108) mmol/L |
| Carbon Dioxide | | 21 | (21-31) mmol/L |
| Anion Gap | | 12 | (4-16) |
| BUN | | 16 | (8-24) mg/dL |
| Creatinine | | 0.90 | (0.40-1.10) mg/dL |
| Est GFR (Non-Af Amer) | | >60 | (>59) |
| Est GFR (MDRD) Af Amer | | >60 | (>59) |
| Glucose | | 91 | (70-99) mg/dL |
| Calcium | | 9.1 | (8.6-10.3) mg/dL |
| Total Bilirubin | | 0.5 | (0-1.2) mg/dL |
| AST | | 13 | (0-31) U/L |
| ALT | | 9 | (0-31) U/L |
| Total Protein | | 7.1 | (5.9-8.4) g/dL |
| Albumin | | 4.4 | (4.0-5.1) g/dL |
| Globulin | | 2.7 | (2.0-3.6) g/dL |
| Albumin/Globulin Ratio | | 1.6 | (1.2-2.3) |
| Alkaline Phosphatase | | 66 | (34-104) U/L |
| Lipase | | 46 | (4-58) U/L |
| HCG, Qual | | Negative | (()) |
| Urine Color | Straw | | (()) |
| Urine Appearance | Clear | | (()) |
| Urine pH | 6.5 | | (5.0-7.5) |
| Ur Specific Gravity | <1.005 L | | (1.005-1.03) |
| Urine Protein | Negative | | (NEG) mg/dL |
| Urine Glucose (UA) | Negative | | (NEG) mg/dL |
| Urine Ketones | Negative | | (NEG) mg/dL |
| Urine Blood | Negative | | (NEG) |
| Urine Nitrate | Negative | | (NEG) |
| Urine Bilirubin | Negative | | (NEG) |
| Urine Urobilinogen | 0.2 | | (0.2-1.0) EU/dL |
| Ur Leukocyte Esterase | Negative | | (NEG) |
| Urine RBC | 0 | | (0-2) /hpf |
| Urine WBC | 0-1 | | (0-5) /hpf |
| Ur Squamous Epith Cells | Many | | (()) /lpf |
| Urine Bacteria | Occ H | | (NONE) /hpf |
| Urine Mucus | Few | | (()) /lpf |
| Ur Culture Indicated? | Reflex c/s not done. | | (CSND) |

**MDM/Disposition**

**- Medical Decision Making**

**MDM Note/Critical Care Macro:**

03/21/11 10:57
Charting performed by ED Scribe CoraLee Michaud for Dr. Katt.

03/21/11 18:43
This is a 31-year-old woman who presents emergency Department with biliary colic. Her labs were all normal she is afebrile. Her right upper quadrant tenderness persists. She was informed of her labs and ultrasound results. She was encouraged on a fat free diet and obtain an outpatient surgical evaluation. Given a prescription for Vicodin Prilosec and Zofran. She is

Name: **VANHOUTEN,EVERINE**
MR #: **HM00507788**
DOB: [redacted]1980
encouraged to return to the emergency department for fever chills persistent vomiting worsening pain or new symptoms. She understood her instructions and was anxious for discharge.
**Reviewed the Following:** Lab, Imaging
**Discussed Investigation, Dx and Tx With:** Patient
**Risk, Follow-up Discussed With:** Patient

**- Disposition**

**Time of Disposition:** 13:45
**Disposition:** DC

**- Disposition**

**Primary Diagnosis:** Cholelithiasis

**Condition:** Stable

**Instructions:**
General Emergency Department Discharge Instructions
NARCOTIC PAIN MEDICINE
PROTON PUMP INHIBITORS
NAUSEA
ANTIEMETICS

Signed By: **Katt, Kathleen MD, MD** Date/Time: **03/21/11 1856**
**<Electronically signed by Kathleen Katt MD, MD>**

CC: Henry K. Leeloy, MD.

Hilo Medical Center

HIM ROI LAB RESULTS

Page: 1
Date: 03/23/11 15:00
User: Lancaster, Brooke

VANHOUTEN, EVERINE
31 F [redacted]1980
Attending:
Reason: Abd pain epigastric area

Loc: Emergency Department
Med Rec Num: HM00507788

Bed: -
Visit: HL0010054219
Reg Date: 03/21/11

## Lab Results

| | 03/21/11 11:00 | 03/21/11 10:45 |
|---|---|---|
| WBC | 8.4 | |
| RBC | 4.48 | |
| Hgb | 13.6 | |
| Hct | 39.6 | |
| MCV | 88.6 | |
| MCH | 30.5 | |
| MCHC | 34.4 | |
| RDW | 13.4 | |
| Plt Count | 382 | |
| Neut % | 52 | |
| Lymph % | 38 | |
| Mono % | 7 | |
| Eos % | 2 | |
| Baso % | 1 | |
| Differential Method | Auto | |
| Absolute Neutrophil | 4.40 | |
| Absolute Lymphocytes | 3.20 | |
| Absolute Monocytes | 0.60 | |
| Absolute Eosinophils | 0.10 | |
| Absolute Basophils | 0.10 | |
| Sodium | 139 | |
| Potassium | 4.1 | |
| Chloride | 106 | |
| Carbon Dioxide | 21 | |
| Anion Gap | 12 | |
| BUN | 16 | |
| Creatinine | 0.90 | |
| Est GFR (Non-Af Amer) | >60 | |
| Est GFR (MDRD) Af Amer | >60 | |
| Glucose | 91 | |
| Calcium | 9.1 | |
| Total Bilirubin | 0.5 | |
| AST | 13 | |
| ALT | 9 | |
| Total Protein | 7.1 | |
| Albumin | 4.4 | |
| Globulin | 2.7 | |
| Albumin/Globulin Ratio | 1.6 | |
| Alkaline Phosphatase | 66 | |
| Lipase | 46 | |
| HCG, Qual | Negative | |
| Urine Color | | Straw |
| Urine Appearance | | Clear |
| Urine pH | | 6.5 |
| Ur Specific Gravity | | <1.005 L |
| Urine Protein | | Negative |
| Urine Glucose (UA) | | Negative |

Continued on Page 2

VANHOUTEN,EVERINE Loc:Emergency Department Bed:-
31 F [redacted]/1980 Med Rec Num:HM00507788 Visit:HL0010054219

Lab Results - Continued

| | | | |
|---|---|---|---|
| Urine Ketones | | Negative | |
| Urine Blood | | Negative | |
| Urine Nitrate | | Negative | |
| Urine Bilirubin | | Negative | |
| Urine Urobilinogen | | 0.2 | |
| Ur Leukocyte Esterase | | Negative | |
| Urine RBC | | 0 | |
| Urine WBC | | 0-1 | |
| Ur Squamous Epith Cells | | Many | |
| Urine Bacteria | | Occ H | |
| Urine Mucus | | Few | |
| Ur Culture Indicated? | | Reflex c/s not done. | |

**Hilo Medical Center**
*We Care for Our Community*
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)974-4700

# Diagnostic Imaging Report

**Signed**

Patient: **VANHOUTEN,EVERINE**
Account: **HL0010054219**
Medical Record: **HM00507788**

DOB: [redacted]/1980
Loc: **HLED**
Rm/Bd:

Age: **31**
Sex: **F**
Status: **DEP ER**

Exam: US ABDOMEN LTD
Accession: A0000006881
Reason For Exam: chole
Ordering Physician: Katt, Kathleen MD, MD

Service Date: **03/21/11**
Service Time: **1132**

---

LIMITED ABDOMINAL ULTRASOUND:
Study limited to the right upper quadrant.

FINDINGS:
The liver surface is smooth. There are no intrahepatic masses or intrahepatic ductal dilatation.

There is a 4-mm echogenic foci in the gallbladder consistent with a small stone. The gallbladder wall looks normal at 2.3 mm.

Common duct stone, left, 2.1 mm.

The pancreatic head and body are grossly normal. Tail is not seen.

Right kidney 8.4 cm. There is no hydronephrosis or nephrolithiasis.

IMPRESSION:
Cholelithiasis.

EW:rp
D: 03/21/2011 13:39:49
T: 03/23/2011 07:37:23

This document was electronically signed by ERIC WYATT, MD. on 03/24/2011 07:13:39.

——— ADDENDUM ———
There is no common duct stone on the left side as initially reported. Rather, the common bile duct measures 2.1 mm.
MP:dml D:4/1/11 T:4/2/11

This document was electronically signed by ERIC WYATT, MD. on 04/04/2011 12:31:39.

# Diagnostic Imaging Report

**Signed**

Patient: **VANHOUTEN,EVERINE**
Account: **HL0010054219**
Medical Record: **HM00507788**

DOB: [redacted]**1980**
Loc: **HLED**
Rm/Bd:

Age: **31**
Sex: **F**
Status: **DEP ER**

Exam: US ABDOMEN LTD
Reason For Exam: chole
Ordering Physician: Katt, Kathleen MD, MD

Accesion:

Hilo Medical Center
HIM RDI LEGAL RECORD
Page: 1
Date: 03/23/11 15:00
User: Lancaster,Brooke

VANHOUTEN,EVERINE Loc:Emergency Department Bed:-
31 F [redacted]/1980 Med Rec Num:HM00507788 Visit:HL0010054219
Attending: Reg Date:03/21/11
Reason: Abd pain epigastric area

## Allergies

No Known Allergies Allergy (Unverified 03/21/11 10:40)

## Clinical Data

| | |
|---|---|
| Does the patient have a living will? | Uninterested |
| COA signed | Yes |

## Emergency Department Activity

| | | | |
|---|---|---|---|
| Last Name: | VANHOUTEN | Status: | DISCHRGD |
| First Name: | EVERINE | Priority: | Urgent |
| Middle: | | Condition: | Stable |
| Birthdate: | [redacted]/1980 | Arrival Date/Time: | 03/21/11 10:23 |
| Age: | 31 | Arrival Mode: | PRIVATE VEHICLE |
| Sex: | F | Triaged At: | 03/21/11 10:41 |
| Language: | English | Time Seen by Provider: | 03/21/11 10:59 |

Stated Complaint: Abd pain epigastric area
Chief Complaint: Abdominal Pain

ED Location: Emergency Department
Area:
Station:
Group:
ED Provider: Katt,Kathleen MD
ED Midlevel Provider:
ED Nurse: Rivera,Merceda S
Primary Care Provider: Leeloy,Henry K.

## Notes

03/21/11 10:43 Nursing Triage HPI Note by Asahara,Elizabeth
Hx of epigastric pain onset 1900 yesterday. Nausea, no vomiting or diarrhea, Discomfort relieved with tylenol, but pain returns.

03/21/11 11:09 Nurse Note by Rivera,Merceda S
Pt presents to room with 6/10 epigastric pain radiating to back, worsening w/palpation. Reports pain started last evening at approx 1700. Pt reports feeling nauseated w/no emesis. Ate regular diet last evening. This morning had some water and a piece of chocolate. Denies diarrhea. 20G IV placed to right AC. Urine sent and labs drawn and sent. Pt with stable VS at this time.

03/21/11 11:29 Nurse Note by Rivera,Merceda S
Dr. Katt in to assess patient.

03/21/11 13:26 Nurse Note by Rivera,Merceda S

Continued on Page 2

# FOOTNOTE 13

(2a)

PATIENT REGISTRATION FORM
HILO MEDICAL CENTER
1190 WAIANUENUE AVE HILO, HI 96720

MED REC#: HM00507788 NAME: VANHOUTEN,EVERINE A VIP CONF

ACCOUNT#: [redacted]1 ADMIT DATE: 04/14/11 TIME: 0705 DISCHG DATE:
BIRTHDATE: SERV/LOC: HISS SOC SEC#: XXX-XX-3768
AGE: 31 ROOM/BED: PAT STATUS: DEP SDC
SEX: F RACE: WHITE/CAUCASIAN ADM CLERK: ANARIDO
FIN CLASS: QHMSA ADMIT SOURCE: PATIENT CAME FROM HO
INS DIAG: 574.20 REASON: CHOLELITHIASIS NOS
INS AUTH: Track# 1109100029
INS Procedure 1: Proc 2: Proc 3: Proc 4:

*** PATIENT INFORMATION ***

PATIENT: VANHOUTEN,EVERINE A MARITAL ST: NEVER MARRIED
ADDRESS: STR RELIGION: NONE

PHONE HM#: ([redacted]0 PHONE WK#:

*** PHYSICIAN INFORMATION ***

PRIMARY CARE PHYS: Henry K. Leelpy, MD. FAMILY PHYS:
ADMIT PHYSICIAN: OTHER PHYS:
ATTENDING/ER PHYS: Joshua Pierce, MD

*** CONTACT INFORMATION ***

NEXT OF KIN: VANHOUTEN,BARBARA PERSON TO NOTIFY: VANHOUTEN,BARBARA
NOK ADDRESS: PERSON NOTIFY ADD:

NOK PHONE #: ( PERSON NOTIFY PH#: (
NOK OT PH #: PERSON OT PH#:

*** GUARANTOR INFORMATION ***

GUARANTOR NAME: VANHOUTEN,EVERINE GUAR EMPLOYER: BAMBOO GARDEN
GUAR ADDRESS: TR GUAR EMP PH #:
RELATIONSHIP: PATIENT
GUAR PHONE NO: GUARANTOR SS#: XXX-XX-3768

| INSURANCE | POLICY # | GROUP # | SUBSCRIBER |
|---|---|---|---|
| 1 Quest/HMSA<br>PO Box 3520,Honolulu,HI 96811<br>(808)948-6464 | [redacted] | | VANHOUTEN,EVERINE A |
| 2 | | | |
| 3 | | | |

*** ADVANCE DIRECTIVES ***

Advanced Directive:N Name:
What type:

Do you have a living will?
HIPAA Notice Provided? 03/21/11 COA signed? Y If no?

COMMENT:

**Hilo Medical Center**
*We Care for Our Community*
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)974-4700

Report Status: Signed

Patient: **VANHOUTEN,EVERINE**
DOB: **30**
Medical Record: **HM00507788**
Account: **HL0010056211**

DATE OF ADMISSION: 04/14/2011

REFERRING PHYSICIANS: Henry Lee Loy, MD.

REASON FOR ADMISSION: Gallstones.

CLINICAL SUMMARY: This is a 31-year-old female who experienced epigastric and right upper quadrant abdominal pain 10 days earlier. She describes this as sharp, severe, lasting for several hours prior to resolution. There is no history of similar discomfort and she has not experienced this pain subsequently. She presented to the emergency room for evaluation. Laboratory studies were unremarkable. An ultrasound demonstrated cholelithiasis. She is now referred for consideration of cholecystectomy.

She did not experience associated shortness of breath, chest pain. She denies dark urine or light-colored stool. She did not experience nausea or vomiting. She denies fevers. She does admit to bright red blood on the toilet paper with wiping and occasionally in the toilet bowl water. Dr. Lee Loy is planning referral for colonoscopy as there is a family history of colon cancer.

PAST MEDICAL HISTORY: None.

PAST SURGICAL HISTORY: Breast augmentation 2008.

MEDICATIONS: None.

ALLERGIES: None.

FAMILY HISTORY: There is a family history of colon cancer in her grandmother, breast cancer in a different grandmother. There is no history of reaction to anesthesia.

SOCIAL HISTORY: She does not smoke or drink alcohol. She is not working presently.

REVIEW OF SYSTEMS: A comprehensive review of systems questionnaire is attached in the office chart and reviewed with the patient.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature is 98.1?F, blood pressure 147/101, heart rate is 100.
GENERAL: Well appearing, in no distress.
HEENT: Eyes: Gaze is conjugate. There is no scleral icterus.
NECK: Trachea is midline. There is no cervical adenopathy or thyromegaly.
CHEST: Breath sounds are clear bilaterally. Breathing is unlabored.
CARDIAC: Heart is regular in rate and rhythm. No extra heart sounds or murmurs.
ABDOMEN: Soft, nontender. There is no obvious organomegaly or mass.
MUSCULOSKELETAL: Upper and lower extremities range normally. Gait is unremarkable.
LYMPHATIC: There is no cervical adenopathy. There is no lymphedema.
VASCULAR: There are palpable radial pulses. There is no obvious evidence of venous insufficiency or peripheral vascular disease.

IMPRESSION: Biliary colic.

PLAN: I had a long discussion with Ms. Vanhouten regarding the nature of cholelithiasis versus biliary

Name: **VANHOUTEN,EVERINE**
MR #: **HM00507788**
DOB: [redacted]**1980**

colic versus cholecystitis and the various treatment options at this time. Her history and ultrasound are suggestive of biliary colic. I offered observation versus laparoscopic cholecystectomy; she chooses the latter and I agree.

I described the procedure of laparoscopic cholecystectomy in detail, specifically reviewing the risk of bleeding, infection, death, postoperative bile leak requiring percutaneous drainage or reoperation, conversion to an open procedure, common duct injury, persistent pain secondary to a non-therapeutic procedure, post cholecystectomy syndrome including diarrhea, visceral injury requiring laparotomy. She understands and wishes to proceed. I will schedule the procedure at her convenience.

Ms. Vanhouten is clearly instructed to contact me should she experience recurrent pain to any degree, fever, dark urine or light-colored stool, or should she have any concerns. She does understand the risk of interval cholecystitis while awaiting elective cholecystectomy.

PREOPERATIVE CHECKLIST:
1. CBC, CMP.
2. Urine HCG.
3. Referral to Dr. Lee Loy preoperatively for evaluation of blood pressure.
4. Hold Excedrin x5 days.

Joshua Pierce, M.D.
JP:ta
D: 04/01/2011 14:07:50
T: 04/04/2011 15:27:46

cc:
Henry Lee Loy, MD
This document was electronically signed by Joshua Pierce, M.D. on 04/01/2011 17:03:53.

CORRECTION: 04/04/2011

Account # added.
This document was electronically signed by Joshua Pierce, M.D. on 04/04/2011 17:25:15.

# History & Physical

Hilo Medical Center
*We Care for Our Community*

1190 Walanuenue Avenue, Hilo, HI 96720

VANHOUTEN, EVERINE
[redacted]
DOB:
DATE OF OFFICE VISIT: 4-1-2011
**DATE OF ADMISSION:** 04/14/2011

[redacted] F
VANHOUTEN, EVERINE
[redacted]

**REFERRING PHYSICIANS:** Henry Lee Loy, MD.

**REASON FOR ADMISSION:** Gallstones.

**CLINICAL SUMMARY:** This is a 31-year-old female who experienced epigastric and right upper quadrant abdominal pain 10 days earlier. She describes this as sharp, severe, lasting for several hours prior to resolution. There is no history of similar discomfort and she has not experienced this pain subsequently. She presented to the emergency room for evaluation. Laboratory studies were unremarkable. An ultrasound demonstrated cholelithiasis. She is now referred for consideration of cholecystectomy.

She did not experience associated shortness of breath, chest pain. She denies dark urine or light-colored stool. She did not experience nausea or vomiting. She denies fevers. She does admit to bright red blood on the toilet paper with wiping and occasionally in the toilet bowl water. Dr. Lee Loy is planning referral for colonoscopy as there is a family history of colon cancer.

**PAST MEDICAL HISTORY:** None.

**PAST SURGICAL HISTORY:** Breast augmentation 2008.

**MEDICATIONS:** None.

**ALLERGIES:** None.

**FAMILY HISTORY:** There is a family history of colon cancer in her grandmother, breast cancer in a different grandmother. There is no history of reaction to anesthesia.

**SOCIAL HISTORY:** She does not smoke or drink alcohol. She is not working presently.

**REVIEW OF SYSTEMS:** A comprehensive review of systems questionnaire is attached in the office chart and reviewed with the patient.

**PHYSICAL EXAMINATION:**

VITAL SIGNS: Temperature is 98.1°F, blood pressure 147/101, heart rate is 100.
GENERAL: Well appearing, in no distress.
HEENT: Eyes: Gaze is conjugate. There is no scleral icterus.
NECK: Trachea is midline. There is no cervical adenopathy or thyromegaly.
CHEST: Breath sounds are clear bilaterally. Breathing is unlabored.
CARDIAC: Heart is regular in rate and rhythm. No extra heart sounds or murmurs.
ABDOMEN: Soft, nontender. There is no obvious organomegaly or mass.



Chart copy

VANHOUTEN, EVERINE
#[redacted]
DOB: [redacted]

[redacted] F
VANHOUTEN, EVERINE
[redacted]

Hilo Medical Center
We Care for Our Community

MUSCULOSKELETAL: Upper and lower extremities range normally. Gait is unremarkable.
LYMPHATIC: There is no cervical adenopathy. There is no lymphedema.
VASCULAR: There are palpable radial pulses. There is no obvious evidence of venous insufficiency or peripheral vascular disease.

**IMPRESSION:** Biliary colic.

**PLAN:** I had a long discussion with Ms. Vanhouten regarding the nature of cholelithiasis versus biliary colic versus cholecystitis and the various treatment options at this time. Her history and ultrasound are suggestive of biliary colic. I offered observation versus laparoscopic cholecystectomy; she chooses the latter and I agree.

I described the procedure of laparoscopic cholecystectomy in detail, specifically reviewing the risk of bleeding, infection, death, postoperative bile leak requiring percutaneous drainage or reoperation, conversion to an open procedure, common duct injury, persistent pain secondary to a non-therapeutic procedure, post cholecystectomy syndrome including diarrhea, visceral injury requiring laparotomy. She understands and wishes to proceed. I will schedule the procedure at her convenience.

Ms. Vanhouten is clearly instructed to contact me should she experience recurrent pain to any degree, fever, dark urine or light-colored stool, or should she have any concerns. She does understand the risk of interval cholecystitis while awaiting elective cholecystectomy.

**PREOPERATIVE CHECKLIST:**

1. CBC, CMP.
2. Urine HCG.
3. Referral to Dr. Lee Loy preoperatively for evaluation of blood pressure.
4. Hold Excedrin x5 days.

Joshua Pierce, M.D.

JP:ta
D: 04/01/2011 14:07:50
T: 04/04/2011 15:27:46

cc: Henry Lee Loy, MD
This document was electronically signed by Joshua Pierce, M.D. on 04/01/2011 17:03:53.

**CORRECTION: 04/04/2011**

Account # added.
This document was electronically signed by Joshua Pierce, M.D. on 04/04/2011 17:25:15.

I have examined this patient and found no changes in the H&P to contradict planned surgery today.

Sig:_____

Date: Time:

Chart copy

**Hilo Medical Center**
*We Care for Our Community*
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)974-4700

Report Status: Signed

Patient: **VANHOUTEN,EVERINE A**
DOB: [redacted]
Medical Record: **HM00507788**
Account: **HL0010056211**

POSTOPERATIVE DIAGNOSIS: Cholelithiasis.
OPERATIVE PROCEDURE: Laparoscopic cholecystectomy.
SURGEON: Joshua Pierce, M.D.
ANESTHESIOLOGIST: Randall Gerber, M.D.
ANESTHESIA: General.
BLOOD LOSS: Minimal.
FINDINGS: Cholelithiasis.
DISPOSITION: PACU, extubated, stable.

PROCEDURE:
Patient was prepped in the supine position. A 1cm supraumbilical incision was created with scalpel. Subcutaneous tissue was divided with cautery. Midline fascia was identified and entered sharply, and a blunt port could be placed under direct vision. The abdomen could be insufflated without difficulty. A 10 mm step port was placed at the epigastrium under direct vision. Two 5 mm step ports were placed at the right upper quadrant and right lateral abdominal wall with a five step port. The gallbladder could be grasped from the lateral most port and retracted towards the patient's right shoulder. A clear window was developed between the cystic duct, cystic artery, and liver posteriorly at the level of the cystic duct/ cystic neck junction. Three clips were placed across the cystic duct and two across the cystic artery. Both structures were then sharply transected. The gallbladder could be raised from the liver with cautery, with care to keep all electrodissection well away from the porta. The right upper quadrant was irrigated. All clips were found to be intact, and there was no bleeding or bilious drainage. The gallbladder was placed in an endo-catch bag and brought through the umbilical port. All ports were removed under direct vision. Midline fascia was closed with interrupted figure-of-eight 0-Vicryl suture. All port skin incisions were closed with 4-0 Biosyn subcuticular fashion. She awoke without difficulty and transferred to PACU in stable condition. All counts were correct.

Joshua Pierce

JP:dv
D: 04/14/2011 10:27:12
T: 04/14/2011 14:31:15
Job ID: 100382

CC: HENRY LEELOY

This document was electronically signed by Joshua Pierce on 04/14/2011 16:29:20

# FOOTNOTE 14

**Hilo Medical Center**
*We Care for Our Community*
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)974-4700

Report Status: Signed

Patient: **VANHOUTEN,EVERINE A**
DOB: [redacted]
Medical Record: **HM00507788**
Account: **HL0010058387**

DATE OF ADMISSION: 04/14/2011
DATE OF DISCHARGE: 04/15/2011

REFERRING PHYSICIAN: Henry Leeloy, M.D.

PRINCIPAL DIAGNOSIS:
Urinary retention.

OPERATIVE PROCEDURE:
None.

CLINICAL SUMMARY:
This is a 31-year-old female status laparoscopic cholecystectomy 24 hours earlier. She was discharged to home without incident. She did experience urinary retention subsequently and required placement of Foley catheter in the emergency room last evening. She wished to remain hospitalized overnight and I agree this was reasonable.

This morning, she has minimal discomfort, denies nausea, and has tolerated clear liquids. She will advance her diet as tolerated and her Foley catheter will be removed this morning. So long as she is able to void and feels otherwise improved, she may be discharged to home today.

This will qualify as a 24 hour observation. Her discharge instructions are as attached in her medical chart.

Joshua Pierce

JP:dv
D: 04/15/2011 07:58:17
T: 04/15/2011 15:37:20
Job ID: 100483

CC: HENRY LEE LOY MD

This document was electronically signed by Joshua Pierce on 04/15/2011 17:56:30

# FOOTNOTE 15

VANHOUTEN, EVERINE A
[redacted]7

**Gastroenterology Associates**

William A. Hartman, M.D. Timothy C. Jahraus, M.D.

134 Pu'uhonu Way • Hilo, Hawaii 96720-2067 • (808)969-3979 • fax: (808)935-7657

**Patient Name: Vanhouten, Everine**
**DOB:** [redacted]
**Hospital Medical Record #: 507788**

**DOS: April 21, 2011**
**Date of Admission: April 21, 2011**

## HOSPITAL ADMISSION AND PHYSICAL EXAMINATION

**REASON FOR ADMISSION:**

21 year old woman with recent cholecystectomy with recent onset of abdominal pain and findings of abnormal liver-related chemistries.

**HISTORY OF PRESENT ILLNESS:**

This 31-year-old woman has undergone recent cholecystectomy. She reports he onset of upper abdominal pain yesterday. This came on very suddenly was located in the epigastric area and radiated to the back. The symptoms were very reminiscent of the previous experience gallbladder pain. She presented himself to the emergency room at Kona hospital where an evaluation was performed. She was noted to have significantly elevated hepatic transaminases and dilated intrahepatic biliary tree on CT imaging. She is now referred for ERCP.

**PAST MEDICAL HISTORY:**

Drug allergies: None
Current prescribed medications: Vicodin
Surgical history: Cholecystectomy, breast augmentation.

**REVIEW OF SYSTEMS:**

No chronic medical problems are identified. She recently experienced hematochezia without a change in bowel habits.

**SOCIAL HISTORY:**

The patient is single. She does not smoke or drink alcohol.

**FAMILY HISTORY:**

Family history is notable for a grandmother with history of colon cancer.

**PHYSICAL EXAMINATION:**

In general, patient is a well-developed, well-nourished woman
BP: 131/77 Pulse: 85 BMI: 26.5
HEENT exam: Not performed.
Neck: No adenopathy or thyroid enlargement is noted.
Lungs: Clear to auscultation and percussion.
Cardiac exam: The rhythm is regular. There is no murmur or gallop identified.
Abdomen: Soft. Bowel sounds are present and normal in character. There is no hepatosplenomegaly, abdominal mass or tenderness on palpation.

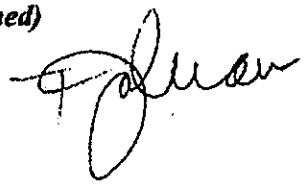
**ASSESSMENT:**
Suspect choledocholithiasis.

5077881/10059507

**PLAN:**
ERCP will be carried out urgently. I discussed the options of management including a period of observation allowing for spontaneous passage of stones versus ERCP intervention. The risks of each alternative were discussed with the patient and she prefers to proceed with the ERCP today. We'll make arrangements for this urgently.

Timothy C. Jahraus, M.D.
***(Reviewed/electronically signed)***

TCJ:



# FOOTNOTE 16

**Hilo Medical Center**
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1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)974-4700

# Diagnostic Imaging Report

**Signed**

Patient: **VANHOUTEN,EVERINE A**
Account: **HL0010059507**
Medical Record: **HM00507788**

DOB: [redacted]0
Loc: **HLSUR**
Rm/Bd: **222-A**

Age: **31**
Sex: **F**
Status: **ADM IN**

Exam: ERCP BILIARY&PANCREATIC
Accession: A0000011867
Reason For Exam: choledocholithiasis
Ordering Physician: Jahraus, Timothy MD

Service Date: **04/21/11**
Service Time: **1600**

---

ERCP, BILIARY PANCREATIC

FINDINGS:
Two radiographs were obtained showing the endoscope and various segments of the extrahepatic biliary tree.

There are surgical clips at the right upper quadrant and the gallbladder is not opacified. The cystic duct is long and normal in caliber, and appears to joint the common bile duct at its distal course. There are lucent filling defects at the base of the cystic duct, which may be air bubbles or stone.

On the second radiograph, there is visualization of the common bile duct, which appears to be normal in caliber. There is attenuation of the distal common bile duct, but no definite filling defects are seen. The cystic duct is barely visualized at the level of the surgical cholecystectomy clips.

David Camacho

DC:NTS
D: 04/22/2011 09:16:08
T: 04/22/2011 15:53:13
Job ID: 101787

cc: TIMOTHY JAHRAUS
DAVID CAMACHO

This document was electronically signed by David Camacho on 04/22/2011 17:52:39

FOOTNOTE 17

**Hilo Medical Center**
*We Care for Our Community*
1190 Waianuenue Avenue. Hilo, Hawaii 96720
(808)974-4700

Report Status: Signed

Patient: **VANHOUTEN,EVERINE A**
DOB: [redacted]
Medical Record: **HM00507788**
Account: **HL0010060681**
PCP: **Henry K. Leeloy MD**
ED Physician: **Sarubbi, Jo Ann MD**

Verdana 4d

**Medical History**

**Nursing Note:** Agreed With
**Chief Complaint:** Multiple complaints
**Stated Complaint:** back pain,nausea,chills
**Time Seen by Provider:** 04/28/11 22:04
**Source:** Patient
**Historian:** Appears accurate
**Exam Limitations:** None

**- History of Present Illness**

**Onset:** Days
**Severity:** Moderate
**Timing/Duration:** Constant
**Associated Symptoms:** fever/chills, nausea/vomiting

**- History of Present Illness**

**Notes: (location/quality/context):**
Nursing History of Present Illness

04/28/11 22:05 Nursing Triage HPI Note by Sewell,Kapua
States gallbladder surgery 4/14, then "I was seen here last Thursday for the same type of gallbladder type pain and was kept in ER overnight. On the Friday, they found that my liver enzymes were high and the doctor told me it might be because I just had surgery and to follow up with my primary, which I just saw Dr.Leeloy this a.m. who took blood and urine for tests and told me I would know results in 2 days. I started having back pain, chills andnausea which has gotten progressively worse this evening, so that's why I'm here. The Dr.said I might have a UTI, but never gave me results."

04/28/11 22:40
This is a 31 y/o female who recently had a gallbladder surgery on 4/14 and was released on 4/24 from the hospital. The pt presents to the ED today c/o mid back, upper back pain, chills and overall not feeling well that started when she was discharged from the hospital. Her back pain is moderate and constant but does not radiate anywhere. According to the pt, she has had burning sensations when she urinates but it does not feel like a UTI. She is also c/o nausea, chest tightness and constipation. Pt had a BM today but still feels constipated and the pt has not taken any laxatives for it. The pt denies any CP, SOB, rash, cough, or any other complaints at this time. (Sarubbi,Jo Ann MD)

**Allergies/Adverse Reactions:**
**Allergies**

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

No Known Allergies Allergy (Unverified 04/28/11 22:02)

**Home Medications:**
**Ambulatory Orders**

Hydrocodone Bit/Acetaminophen [Vicodin 5-500 Tab] 1 tab PO Q4HP PRN #20 tablet
Mirena

**Past Medical History**

**Past Medical History:** Reports: Other (Increased liver enzymes last visit to ER, UTI's in past)
**Past Surgical History:** Other (gallbladder surgery to widen ducts for possible stones)
**Vaccination Hx:** Yes Influ (4/23/11), No Pneumo (unsure)

**- Social History**

**Personal History:** Employed
**Alcohol:** Reports: Occasional

**Review of Systems**

**Except as noted:** Reviewed and negative
**Constitutional:** Fever, Chills
**Eyes:** denies: Photophobia, Vision Change
**Ears/Nose/Mouth/Throat:** denies: Epistaxis, Rhinorrhea
**Cardiovascular:** Other (chest tightness). denies: Chest Pain
**Respiratory:** denies: Cough, Wheezing
**Gastrointestinal:** Nausea, Constipation. denies: Abdominal Pain, Vomiting, Diarrhea
**Genitourinary:** Other (burning sensation while urinating). denies: Frequency, Incontinence
**Musculoskeletal:** Back Pain (mid back and upper back pain). denies: Neck Pain
**Integumentary:** denies: Pruritis, Rash, Bruising
**Neurological:** denies: Dizziness, Headache
**Psychiatric:** denies: Depression, Anxiety
**Allergic/Immunologic:** denies: Drug Allergy

**Physical Exam**

**Vital Signs Reviewed?:** Yes
**Constitutional:** Well Developed/Nourished, Appears Stated Age, Alert. Not: Distress
**Eyes:** PERRL, EOMI
**Ears/Nose/Mouth/Throat:** Nml ENT Exam. No: JVD
**Cardiovascular:** Regular Rate & Rhythm, Peri Pulses Strg/Eq. No: Murmur, Rub, Gallop
**Respiratory:** BS Normal/Equal Bilat. No: Respiratory Distress, Wheezing, Crackles, Rhonchi
**Gastrointestinal:** Soft, Normal BS. Not: Tender, Right CVAT, Left CVAT
**Abdominal Tenderness:** Not: Present
**Musculoskeletal:** Full ROM, Supple Neck. No: Deformity, Tenderness to Palp, Pedal Edema
**Integumentary:** Normal, Dry
**Neurological:** Alert, Oriented x 3. Not: Focal Findings
**Psychiatric:** Nml Age Behavior, Alert
**Hema/Lymph/Immun:** No: Bleeding Gums, Lymphadenopathy

**Nursing Vital Signs:**

**Initial Vital Signs**

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

| | | |
|---|---|---|
| Temperature | 98.1 | 04/28/11 22:03 |
| Pulse Rate | 85 | 04/28/11 22:03 |
| Respiratory Rate | 18 | 04/28/11 22:03 |
| Blood Pressure | 150/99 H | 04/28/11 22:03 |
| O2 Sat by Pulse Oximetry | 99 | 04/28/11 22:03 |

**Results/Interpretations**

**- X-Ray 1**

**X-Ray interpreted by:** Emergency Physician
**Type of X-Ray and views:** Type (acute)
**X-Ray Notes:**

04/29/11 00:10
CXR-There is no infiltrate or interstitial fluid. There is no free air of diaphragm, no bony abnormalities. abd portion stool thru out the bowel no dilitaion, no a/f levels.no obstruction

**- Laboratory**

**Result Note:**

04/28/11 22:43

| | | |
|---|---|---|
| [redacted] | 13.0 | 412 |
| | 38.6 | |

04/28/11 22:30

| | | | |
|---|---|---|---|
| 137 | 105 | 14 | [redacted] |
| 3.9 | 23 | 0.84 | |

**Laboratory Tests**

| | 04/28/11 22:30 | 04/28/11 22:43 | 04/28/11 23:10 | Range/Units |
|---|---|---|---|---|
| WBC | | 11.8 H | | (3.8-11.2) 10(9)/L |
| RBC | | 4.32 | | (3.9-5.2) 10(12)/L |
| Hgb | | 13.0 | | (11.6-15.1) g/dL |
| Hct | | 38.6 | | (34.1-44.2) % |
| MCV | | 89.4 | | (80-100) fL |
| MCH | | 30.0 | | (27-33) pg |
| MCHC | | 33.6 | | (32-36) g/dL |
| RDW | | 13.6 | | (11-15) % |
| Plt Count | | 412 | | (150-450) 10(9)/L |
| Neut % | 41 | | | (40-70) % |
| Lymph % | 47 H | | | (20-45) % |
| Mono % | 7 | | | (4-10) % |
| Eos % | 4 | | | (0-6) % |

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

| | | | | |
|---|---|---|---|---|
| Baso % | 1 | | | (0-2) % |
| Differential Method | Auto | | | (()) |
| Absolute Neutrophil | 4.90 | | | (1.4-7.0) 10(9)/L |
| Absolute Lymphocytes | 5.50 H | | | (0.7-4.5) 10(9)/L |
| Absolute Monocytes | 0.80 | | | (0.1-1.0) 10(9)/L |
| Absolute Eosinophils | 0.50 | | | (0-0.6) 10(9)/L |
| Absolute Basophils | 0.10 | | | (0-0.2) 10(9)/L |
| Sodium | 137 | | | (133-145) mmol/L |
| Potassium | 3.9 | | | (3.3-5.1) mmol/L |
| Chloride | 105 | | | (96-108) mmol/L |
| Carbon Dioxide | 23 | | | (21-31) mmol/L |
| Anion Gap | 9 | | | (4-16) |
| BUN | 14 | | | (8-24) mg/dL |
| Creatinine | 0.84 | | | (0.40-1.10) mg/dL |
| Est GFR (Non-Af Amer) | >60 | | | (>59) |
| Est GFR (MDRD) Af Amer | >60 | | | (>59) |
| Glucose | 100 H | | | (70-99) mg/dL |
| Calcium | 9.2 | | | (8.6-10.3) mg/dL |
| Total Bilirubin | 0.5 | | | (0-1.2) mg/dL |
| AST | 31 | | | (0-31) U/L |
| ALT | 79 H | | | (0-31) U/L |
| Total Protein | 6.7 | | | (5.9-8.4) g/dL |
| Albumin | 4.3 | | | (4.0-5.1) g/dL |
| Globulin | 2.4 | | | (2.0-3.6) g/dL |
| Albumin/Globulin Ratio | 1.8 | | | (1.2-2.3) |
| Alkaline Phosphatase | 140 H | | | (34-104) U/L |
| Urine Color | | | Straw | (()) |
| Urine Appearance | | | Sl hazy | (()) |
| Urine pH | | | 5.5 | (5.0-7.5) |
| Ur Specific Gravity | | | 1.023 | (1.005-1.03) |
| Urine Protein | | | Negative | (NEG) mg/dL |
| Urine Glucose (UA) | | | Negative | (NEG) mg/dL |
| Urine Ketones | | | Negative | (NEG) mg/dL |
| Urine Blood | | | Large H | (NEG) |
| Urine Nitrate | | | Negative | (NEG) |
| Urine Bilirubin | | | Negative | (NEG) |
| Urine Urobilinogen | | | 0.2 | (0.2-1.0) EU/dL |
| Ur Leukocyte Esterase | | | Negative | (NEG) |
| Urine RBC | | | 5-10 | (0-2) /hpf |
| Urine WBC | | | 2-5 | (0-5) /hpf |
| Ur Squamous Epith Cells | | | Few | (()) /lpf |
| Urine Bacteria | | | Mod H | (NONE) /hpf |
| Urine Mucus | | | Mod | (()) /lpf |
| Ur Culture Indicated? | | | Reflex c/s done. H | (CSND) |

**MDM/Disposition**

**- Medical Decision Making**

**MDM Note/Critical Care Macro:**

04/29/11 03:23
Charting performed by ED Scribe Elizabeth Lonokapu for Dr. Sarubbi.

Name: **VANHOUTEN,EVERINE A**
MR #: **HM00507788**
DOB: [redacted]

the patient just recently had GB which was complicated by a retained stone.she presents tonight with lower back pain, non radiating. no fever or urinary symtoms. she has taken vicodin for the pain with relief. she also is c/o constipation.she is on colace but has not taken any laxatives.her exam is is not diagnostic.her lab values show a normal WBC, her urine is clean, her LFTS are inmproved. Her xray does show ostipation but no other problems.her pain is tolerable,it could be from the constipation. she was given citrate of mag and instructed to use miralax . she will f/u with her pmd in 1-2 days for re evaluation,if nay changes she will return to the ED

**Reviewed the Following:** Lab, Imaging
**Discussed Investigation, Dx and Tx With:** Patient, Family
**Risk, Follow-up Discussed With:** Patient, Family

**- Disposition**

**Time of Disposition:** 00:44
**Disposition:** DC
**Secondary Diagnosis:** Back Pain- Non specific
**Free Text Diagnosis:** constipation

**- Disposition**

**Condition:** Stable
**Instructions:** HIGH FIBER DIET, CONSTIPATION, General Emergency Department Discharge Instructions

Signed By: **Sarubbi, Jo Ann MD** Date/Time: **05/01/11 2117**
**<Electronically signed by Jo Ann Sarubbi MD>**

CC: Henry K. Leeloy, MD.